**Department of Health**
**Child and Adolescent Mental Health Division**

# *Performance Report*

***Performance Period July 2005-September 2005***

## Introduction

This report presents the first quarter of fiscal year 2006 (July 2005-September 2005) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The information used for this report is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analyses of data provides information that allows stakeholders to determine how well CAMHD is delivering care and impacting child outcomes.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

## How Measures Are Selected and Used

CAMHD has successfully used performance measures over a number of years. The key utility of measuring quality and performance is the ability it gives to align organizational goals with achieving results in core areas of service provision and supporting infrastructure. CAMHD worked through a process of moving from "fear of accountability" and measurement, to counting on the data to allow for open discussion about needed improvements. Measures are used to coordinate the work of the organization in order to achieve timely, cost-effective services that ultimately improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD, at all levels, to look at its performance and use this information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is

performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

## Quality Improvement Activities

In this first full quarter following termination of the Felix Consent Decree, CAMHD has continued to implement its core quality assurance and improvement initiatives. Some of the highlights of the quarter include:

CAMHD completed its annual evaluation of the Quality Assurance and Improvement Program (QAIP). This evaluation was used to revise the QAIP and establish a work plan for the next year. These documents were reviewed, approved, and put into action by the Executive Management Team. The goals and objectives for the current year are to assure: 1) the provision of services by qualified practitioners, 2) the maintenance of the utilization management program which ensures access, availability and appropriate use of services, 3) quality of care and service provision, 4) consumer satisfaction, 5) delegation oversight for credentialing activities, and 6) minimizing fraud and abuse through the compliance program. A full description of these activities can be found at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-1.pdf and http://www.hawaii.gov/health/mental-health/camhd/library/pdf/qaip-4.pdf.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded CAMHD a Comprehensive Community Mental Health Services grant to develop a system of care supporting youth in their transition to adulthood. CAMHD's community partners in this grant include the Susannah Wesley Community Center, Hawaii Families as Allies, Wai Aka Young Adult Support Organization, and the University of Hawaii Center for Disability studies.

In collaboration with the Department of Education and other stakeholder groups, CAMHD has been revising the Interagency Performance Standards and Practice Guidelines. These standards and guidelines are being updated to reflect the state-of-the-art in best practices, evidence-based services, and most promising interventions for youth and families.

The next generation of the CAMHD service array is being constructed through development of a comprehensive Request for Proposals. The new Interagency Performance Standards and Practice Guidelines will be integrated into this updated array. During the quarter CAMHD held Request for Information meetings throughout the state to describe plans for the updated services and to receive public input from many stakeholder groups. CAMHD is currently implementing revisions based on these meetings.

CAMHD is also working to actively solidify its Human Resources and organizational structure. This is being pursued by continuing its reintegration of positions that were exempted from civil service under the consent decree into the civil service system. CAMHD is also actively working on formalizing the remaining structural reorganization

to assure that the organization structure reflects the operational structure developed under the consent decree.

As part of another SAMHSA grant, CAMHD also held its kick-off best practices conference entitled "Creating Cultures of Engagement in Residential Care." A national team of faculty presented the National Association of State Mental Health Program Director's (NASMHPD) National Technical Assistance Center (NTAC) program for reducing the use of seclusion and restraint in residential settings. Organizational leaders and clinicians from CAMHD's private provider network throughout the state attended the conference.

## Overall Summary of Findings

The overall results from the data and analysis presented below suggest that in general, CAMHD's functioning is comparable to that of previous quarters. The total number of youth served decreased slightly as is typical of the summer months, but the total size of the CAMHD population is larger than it was a year ago. Services utilization may have "turned a corner" in that authorization patterns for the quarter suggest that Hospital and Community Residential service utilization began to decrease and utilization of Therapeutic Foster Homes has increased. This service evolution is consistent with the core value of services in the least restrictive environment and represents a positive step forward while room for improvement remains. The proportion of youth enrolled in the QUEST behavioral health plan reached an all-time high since this performance report was initiated, and is consistent with CAMHD's efforts to expanded its revenue from federal sources. Human resources, particularly hiring and retaining qualified mental health care coordinators, remains a challenge that requires ongoing attention to stability in this core infrastructure component.

## Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

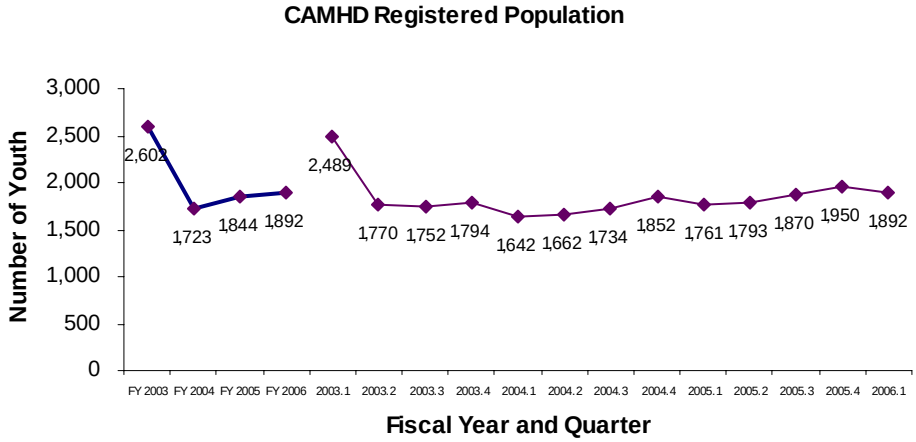
# Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the first quarter of fiscal year 2006 (July 2005-September 2005). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,892 youth across the State, a decrease of 58 from the previous reporting quarter (April 2005-June 2005), or a 3% decrease in the total population. Decreases in the registered population were experienced in more than half of the Family Guidance Centers.

Such a seasonal decrease during the summer months is typical. As depicted below the first quarter registered population is consistently less than the preceding fourth quarter population. In comparison to prior years, the 3% seasonal reduction is less than the 5% reduction witnessed last year, and the 8% reduction witnessed the year before. Consistent with the relative expansion of its Support for Emotional and Behavioral Development (SEBD) services and the movement toward more year round scheduling of school calendars, CAMHD's overall registered population size is apparently becoming less sensitive to reductions coinciding with the summer season.

Further, on a year-to-year basis, CAMHD is continuing to show overall growth in its registered population. In comparison to the same period of last year (July 2004-September 2004), CAMHD has experienced a 7% overall increase in its registered population. Despite this growth, CAMHD continues to serve fewer youth than expected based on estimates of the prevalence of severe emotional an behavioral problems in the general population. Therefore, opportunity likely remains for expanding outreach to unserved populations and increasing overall population size.

The chart below reflects changes in the CAMHD population over time.




Note: The drop in population at the start of fiscal year 2003 (July 2002) corresponds to the shift in management of services to youth with pervasive developmental disorders from CAMHD to the Department of Education.

The number of youth registered at each of the Family Guidance Centers during the first quarter (July 2005-September 2005) is displayed in Table 1. The number for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 22.8% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) serves the largest population on Oahu, and

13.5% of the CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2.1%).

Table 1. Population of Youth Registered by Family Guidance Center, FY 2006, Quarter 1 (July 2005-September 2005)

| COFGC | LOFGC | MFGC | WFGC | HOFGC | HFGC | KFGC | FCLB |
|---|---|---|---|---|---|---|---|
| 168 | 255 | 155 | 149 | 180 | 431 | 514 | 40 |

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 1,011 had services that were authorized within the quarter.

Of the registered population (1,892), 95 youth (5.0%) were newly registered (had not previously received services) in the first quarter of fiscal year 2006. This represents a decrease of 43 new admissions from the previous quarter (April 2005-June 2005). One hundred ten (110) youth (5.8%) who had previously received services from CAMHD were reregistered, an increase from last quarter's readmissions of 97 youth. CAMHD discharged a total of 213 youth during the quarter, or 11.3% of the registered population. This is a decrease of 11 youth from last quarter's discharge of 224 youth, which was 11.5% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal, or moving out of state.

In the context of the seasonal decrease in the overall registered population, this pattern of admissions and discharges suggests that the reduction in the total registered population is resulting from a decrease in the number of new admissions, not an increase in the number of discharges. In other words, the services for youth registered with the system apparently proceeded as is typical, but "gateways" into the system provided fewer youth.

The average age and age range has remained relatively stable among the CAMHD population over the past few years. The average age of registered youth in the reporting quarter was 14.4 years with a range from 3 to 20 years. However, there has been a multiyear tendency toward a decreasing percentage of males and increasing percentage of females in the CAMHD population. However, approximately two-thirds (65%) of youth were male (see Table 2).

Table 2. Gender of CAMHD Youth

| Gender | N | % of Available |
|---|---|---|
| Females | 654 | 35% |
| Males | 1,238 | 65% |

CAMHD is continuing its effort to convert its collection of race and national origin data to be consistent with national standards. The national origin of youth is displayed in

Table 3. The races of youth registered in the reporting quarter are displayed in Table 4. The valid completion rates for the new procedures remains low with 61% of youth missing national origin information and 41% of youth missing race information. To improve the quality of these data fields, additional online reporting capacity was added to the Child and Adolescent Management Information System. Missing data rates for these fields were reviewed during quality committee meetings, and additional training for the Family Guidance Centers is planned.

The high missing data rates make the generality of the available data dubious. However, the observed results are relatively consistent with prior quarters. Multiracial youth represented the largest racial group (61.1%), followed by White youth (17.8%), and then Native Hawaiian or Pacific Islanders (10.8%). National Origin data were not available (no data entered) for 60.6% of youth registered. Race data were somewhat more available last quarter than this quarter when 65.7% had race data recorded. This reflects the continued implementation of the new race and ethnicity recording system developed as part of the data infrastructure grant to meet federal reporting requirements.

Table 3. National Origin of Youth (Unduplicated)

| National Origin | N | % of Available |
|---|---|---|
| Not Hispanic | 531 | 71.2% |
| Hispanic or Latino/a | 215 | 28.8% |
| Not Available (% Total) | 1,146 | 60.6% |

Table 4. Race of Youth (Unduplicated)

| Race | N | % of Available |
|---|---|---|
| American Indian or Alaska Native | 1 | 0.1% |
| Asian | 89 | 7.9% |
| Black or African-American | 15 | 1.3% |
| Native Hawaiian or Pacific Islander | 121 | 10.8% |
| White | 199 | 17.8% |
| Other Race | 11 | 1.0% |
| Multiracial | 684 | 61.1% |
| Based on Observation | 155 | 13.8% |
| Not Available (% Total) | 772 | 40.8% |

Table 5. Agency Involvement

| Agency Involvement | N | % |
|---|---|---|
| DHS | 180 | 9.5% |
| Court | 476 | 25.2% |
| Incarcerated/Detained | 128 | 6.8% |
| SEBD | 714 | 37.7% |
| Quest | 754 | 39.9% |

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5). In the quarter, 9.5% were involved with DHS, which continues a multiyear pattern of a progressively smaller proportion of youth involved with DHS (e.g., 12.4% during the same period of FY 2004). At some point during the quarter, 25.2% had a Family Court

hearing during the quarter, and 6.8% were incarcerated at HYCF or detained at the Detention Home. Both of these proportions increased slightly from the previous quarter (23.4% and 6.3%, respectively) but remain below the same period from last year (27.4% and 8.1%, respectively).

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occurs by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 714 and were 37.7% of the registered population. This was an increase of 59 youth, or a 9% increase in the SEBD category over the previous quarter (January 2005-March 2005).

QUEST-eligible youth who received services in the quarter were 39.9% of the population. This is the highest proportion of QUEST enrolled youth witnessed on this indicator since initiation of this report. Thus, the pattern of expanding services to QUEST youth continues. However, it is important to note that QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or juvenile justice status.

Table 6. Diagnostic Distribution of Registered Youth

| Any Diagnosis of | N | % |
|---|---|---|
| Disruptive Behavior | 791 | 46.2% |
| Attentional | 714 | 41.7% |
| Mood | 608 | 35.5% |
| Miscellaneous | 446 | 26.0% |
| Anxiety | 335 | 19.6% |
| Substance-Related | 276 | 16.1% |
| Adjustment | 197 | 11.5% |
| Mental Retardation | 36 | 2.1% |
| Pervasive Developmental | 29 | 1.7% |
| Multiple Diagnoses | 1,244 | 72.6% |
| Ave. Number of Diagnoses | 1.9 | |

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (46.2%), Attentional disorders (41.7%), and Mood disorders (35.5%). This quarter saw a slight decrease in the number of youth identified with Disruptive Behavior disorders, although there continues to be more youth with Disruptive disorders than those with Attentional disorders. Miscellaneous diagnoses accounted for 26.0% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 72.6% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight increase from the previous quarter (April 2005-June 2005) when 71.8% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (77.8%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-

occurring diagnoses. This continues a long-term pattern of increasing diagnostic comorbidity among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 16.1% of the registered population, an increase of .6% from the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

# Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (July 2005-September 2005). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Home and community based services continue to account for the majority of services provided to youth. Specifically, 46.8% of youth with service authorization received Intensive In-Home (IIH) services and 13.5% received Multisystemic Therapy (MST). These home and community services were provided at a level that was comparable to same period of the prior year, with a small tendency toward greater relative utilization of IIH and lower relative utilization of MST.

Table 7. Service Authorization Summary (July 1, 2005-September 30, 2005).

| Any Authorization of Services | Monthly Average | Total N | % of Registered | % of Served |
|---|---|---|---|---|
| Out-of-State | 6 | 6 | 0.3% | 0.6% |
| Hospital Residential | 19 | 32 | 1.7% | 3.2% |
| Community High Risk | 10 | 10 | 0.5% | 1.0% |
| Community Residential | 121 | 156 | 8.2% | 15.4% |
| Therapeutic Group Home | 73 | 97 | 5.1% | 9.6% |
| Therapeutic Family Home | 139 | 161 | 8.5% | 15.9% |
| Respite Home | 2 | 6 | 0.3% | 0.6% |
| Intensive Day Stabilization | 0 | 0 | 0.0% | 0.0% |
| Partial Hospitalization | 0 | 0 | 0.0% | 0.0% |
| Day Treatment | 0 | 0 | 0.0% | 0.0% |
| Multisystemic Therapy | 99 | 136 | 7.2% | 13.5% |
| Intensive In-Home | 406 | 473 | 25.0% | 46.8% |
| Flex | 107 | 172 | 9.1% | 17.0% |
| Respite | 28 | 32 | 1.7% | 3.2% |
| Less Intensive | 79 | 189 | 10.0% | 18.7% |
| Crisis Stabilization | 8 | 19 | 1.0% | 1.9% |

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (15.4%). The percentage of youth receiving these services

decreased slightly from the previous quarter (15.5%) and from the same period of last year 17.1%). Similarly, the use of Hospital-based Residential (HBR) services (3.2% during period) decreased from the previous quarter (4%) and from the same period of last year (3.9%). This recent decline reverses a trend toward increasing utilization of HBR in recent years.

In addition to this decreasing utilization of the most restrictive out-of-home services, the utilization of Therapeutic Family Homes (15.9%) has increased over the previous quarter (14.9%) and the same period of last year (14.2%). Utilization of Therapeutic Group Homes (9.6%) has fluctuated a bit from quarter to quarter (up from 9.2% in the previous quarter), but is slightly lower than the same period of last year (10.6%).

In the reporting period, services paid for through Flex funding were provided for 17.0% of registered youth, which was comparable to last quarter's utilization of these services for 17.5% of the registered population. CAMHD uses the term "Ancillary Services" for services paid for through flex funding. Ancillary Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. The largest use of Flex funding was to pay for travel cost for youth in out of home settings.

There were 0.6% of youth accessing Respite Home services this quarter. This is a slight increase over last quarter, when there were no youth accessing services. On an annualized basis, utilization has increased somewhat, but overall utilization of this service remains low. Respite Homes were designed to support caregivers' capacities and prevent potential out-of-home placements. The consistently low utilization of this service indicates either little need for this service or that some potential barriers existing to accessing this service. One identified obstacle involves the funding and payment structure for these homes. Therefore, payment is being restructured to remove this obstacle for this level of care within the next generation of the service array. There was also no utilization of Intensive Day Stabilization Services. Respite services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite services has remained relatively stable with 3.2% of youth accessing these services in the quarter.

# Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the fourth quarter of fiscal year 2005 (April 2005-June 2005). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8. Out-of-Home residential treatment services in Hawaii accounted for 83.6% of service expenditures, which is 0.6% above the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 0.8% of total expenditures, which is 0.6% lower than the previous reporting quarter's (January 2005-March 2005) proportion of cost.

Table 8. Cost of Services (April 2005-June 2005)

| Any Receipt of Services | Total Cost ($) | Cost per Youth ($)[a] | Cost per LOC ($)[b] | Cost per LOC per Youth ($)[b] | % of LOC Total ($)[b] |
|---|---|---|---|---|---|
| Out-of-State | 112,808 | 14,101 | 96,171 | 12,021 | 0.8% |
| Hospital Residential | 1,381,989 | 32,139 | 1,017,818 | 23,670 | 8.6% |
| Community High Risk | 569,473 | 47,456 | 545,985 | 45,499 | 4.6% |
| Community Residential | 4,818,049 | 29,926 | 4,240,055 | 26,336 | 35.7% |
| Therapeutic Group Home | 2,537,356 | 25,374 | 2,027,786 | 20,278 | 17.1% |
| Therapeutic Family Home | 2,564,990 | 16,031 | 2,095,085 | 13,094 | 17.6% |
| Respite Home | 6,481 | 6,481 | 200 | 200 | 0.0% |
| Intensive Day Stabilization | 0 | 0 | 0 | 0 | 0.0% |
| Partial Hospitalization | 6,750 | 6,750 | 6,750 | 6,750 | 0.1% |
| Day Treatment | 0 | 0 | 0 | 0 | 0.0% |
| Multisystemic Therapy | 862,433 | 5,711 | 452,068 | 2,994 | 3.8% |
| Intensive In-Home | 2,136,737 | 4,537 | 1,018,291 | 2,162 | 8.6% |
| Flex | 4,633,939 | 24,135 | 271,487 | 1,414 | 2.3% |
| Respite | 184,943 | 4,624 | 47,048 | 1,176 | 0.4% |
| Less Intensive | 119,267 | 23,853 | 11,433 | 2,287 | 0.1% |
| Crisis Stabilization | 160,110 | 6,671 | 47,015 | 1,959 | 0.4% |

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). [b] Cost per LOC represents unduplicated cost (US$) for services at the specified level of care.

As previously noted, the number of youth receiving Hospital Residential services had been increasing recently. However, with the increased census, the current quarter witnessed a decrease in the average length of service in the Hospital setting. Accordingly, the total cost of services for youth who received Hospital Residential services during the quarter increased from $1,254,862 to $1,381,989, the cost for the Hospital Residential services only remained relative stable ($1,017,818 compared to $1,023,146 in the prior quarter) and the cost per youth decreased ($39,214 to $32,139 for total costs; $31,973 to $23,670 for Hospital Residential costs only).

Prior to the decrease in authorization of Community-Based Residential (CBR) during the first quarter of fiscal year 2006, utilization of this service had been historically increasing. Accordingly, the cost of CBR services increased slightly in the reporting quarter (i.e., fourth quarter compared to third quarter of fiscal year 2005) both in terms of total dollars and average cost per youth. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($45,499 per youth), which has been consistent over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($13,094 per youth), which again, has been consistent over time.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 12.4% of the unduplicated cost of services, which is a slight decrease from the last reporting quarter (January 2005-March 2005) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,537 per youth ($2,162 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

For those youth who received Ancillary Services, average cost per youth for the Flex funded services only was $1,414 per month and the average cost for all services to those youth who received one or more Ancillary services was $24,135 per youth. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel-related including family visits when placement is off-island. CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.

Recent developments to the chart of accounts in the financial accounting system allows for more specific coding of purchases into specific service categories. Therefore, as the system continues to develop and new reporting functions are programmed, comprehensive financial reports providing detailed service expenditures should be available from FAMIS. This should lead to reduced burden for manual reporting and increase the capacity of the fiscal section to perform timely and thorough financial analysis.

# Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youths with mental retardation and/or developmental disabilities and/or autism (target population) who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that these children could receive appropriate individualized supports consistent with national best practices in developmental disabilities.

The table below summarizes the expenditure of dollars for respite services provided by DDD from July 1, 2002 through June 30, 2005:

Table 9. Expenditures to Date for Respite by Island

| Island | # Youth Served | % of Total Youth | Total Cost Per Island | % of Total Dollars Expended | Average Cost Per Youth |
|---|---|---|---|---|---|
| Oahu | 73 | 55% | $148,303.93 | 44% | $2,031.56 |
| Hawaii | 34 | 26% | $89,714.00 | 27% | $2,638.65 |
| Kauai | 11 | 8% | $61,644.50 | 18% | $5,604.05 |
| Maui | 14 | 11% | $37,358.00 | 11% | $2,668.43 |
| Total Youth | 132 | Total Dollars Expended (July 2002 - June 30, 2005) | | | $337,020.43 |

Note: There are currently no reports of respite expenditures for the period July 2005 through September 2005.

Although the MOA ended on June 30, 2004, DDD continues to provide case management, individual support, respite, and out-of-home support services for the identified target population. DDD utilized the respite monies transferred from CAMHD as part of its state match for its HCBS-DD/MR Medicaid waiver program, thereby maximizing state funds and qualifying DDD services for federal reimbursement.

### *Respite Services*

The target population received at least one support service from the DDD service system. For this current quarter, July 1, 2005 through September 30, 2005, the following table shows the utilization of various DDD funded services (short term) that families accessed to meet their needs:

Table 10. Other Service Options Utilized by Respite Recipients

| DDD Funded Services | # of Users |
|---|---|
| Purchase of Services - Partnerships in Community Living | 6 |
| DOH - DDD Respite | 35 |
| Family Support Services Program | 11 |

In addition, since July 2002, DDD has admitted 57 of the target population into the Home and Community Based Services – DD/MR (HCBS-DD/MR) Medicaid waiver program. Of the 57 individuals, 6 were admitted in the last months of the FY '05 or the first quarter of FY '06. Three clients were discharged from HCBS-DD/MR waiver services; one client moved out of state and two were discharged at the guardian's request.

Based on the latest FY '05 expenditure information, the following table shows the number of clients and total dollars spent for two of the HCBS-DD/MR Medicaid waiver services, respite and personal assistance:

Table 11. Waiver Service Options Utilized by Respite Recipients

| Waiver Services | # of Clients | Total $ |
|---|---|---|
| Respite | 6 | $55,103.00 |
| Personal Assistance | 41 | $1,223,941.00 |

Note: Amounts are rounded off to the nearest dollar.

### *Residential Services*

DDD extended the Individual Community Residential Support (ICRS) contract until June 2006. Currently, ICRS currently provides for special treatment facility services for two youths. In September 2005, one of the youth who previously transitioned to an Adult Foster Home was returned because the placement did not work out. Another prospective Adult Foster Home has been identified and the DOH DDD case manager will continue to oversee and coordinate services for this youth.

All but one individual of the thirteen youths that originally received ICRS services have been admitted to the HCBS-DD/MR waiver program. This one individual remains in a psychiatric facility, and, although discharge has been recommended, transition to community-based services has not occurred.

# Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

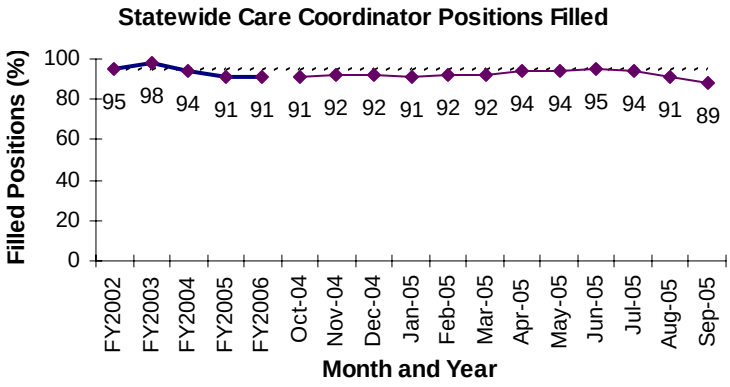
Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

*CAMHD will maintain sufficient personnel to serve the eligible population*

Goal:

⇨ 95% of mental health care coordinator positions are filled. *

Over the reporting period, CAMHD had an average of 91% of care coordinator positions statewide filled, which was 4% below the performance goal. This performance is slightly below last quarter's average of 94% of positions filled. The quarter began with the performance goal being met at 95% of positions filled, but new vacancies during the period led to a decline in performance. This quarter's results reflects the eighth consecutive quarter the performance goal was not met since this indicator began to be reported at the start of FY 2002. The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to impact performance on this goal.




The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

| COFGC | LOFGC | MFGC | WOFGC | HOFGC | HFGC | KAUAI |
|---|---|---|---|---|---|---|
| 92% | 97% | 87% | 88% | 100% | 88% | 89% |

Vacancies in Central Oahu, Maui, Windward Oahu, Hawaii, and Kauai centers were below the performance target for the quarter. Aside from the fact that Honolulu Oahu has had a stable care coordination workforce, a clear pattern of vacancies has not emerged. Each of the other centers has

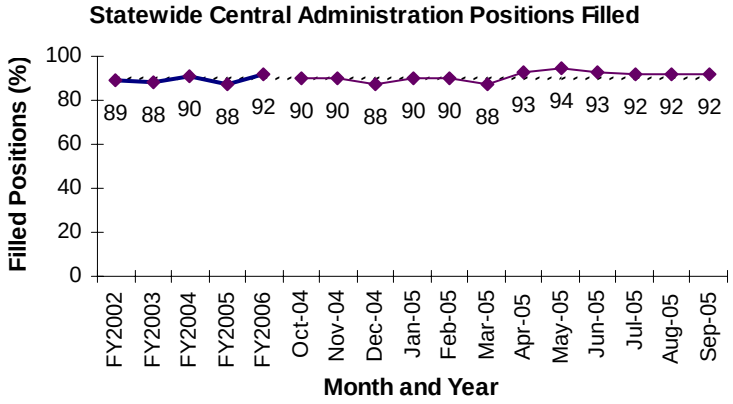
experienced one to two vacancies. Therefore, this performance pattern may reflect a relatively stable pattern of employee turnover coupled with challenges in rapidly hiring new workers. As a strategy to improve human resource management, Branch Chiefs will receive weekly briefings from the CAMHD personnel office to facilitate communication and understanding when hiring obstacles are encountered.

Goal:

⇨ 90% of central administration positions are filled. *

The performance target met the desired performance with an average of 92% of central administration positions filled over the quarter. This is slightly below last quarter's performance of 93%, and is the second consecutive quarter that the goal was met.

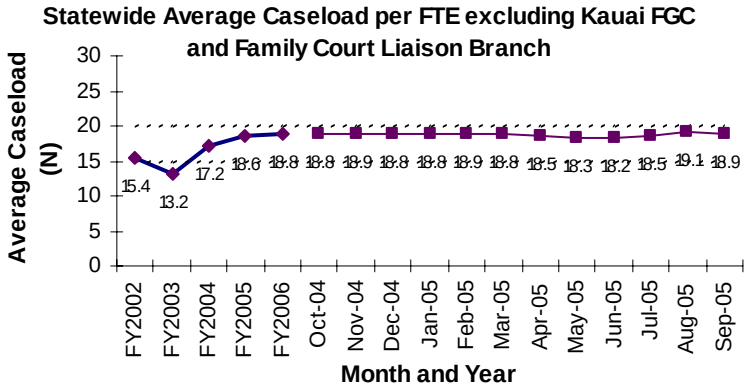
Vacant positions are distributed throughout central administration, with all offices experiencing some vacancies. Vacant positions are reviewed and recruited through the civil service system as appropriate to support the realignment of exempt and civil service positions. The long-standing vacancy in the Transition Specialist position in the Clinical Services Office was recently filled.




Goal:

⇨ Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.

The statewide average caseload for the first quarter was within the target range at 18.8 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have consistently been in the targeted range since the beginning of fiscal year 2004 and have tended to be in the high end of the range over the past year.




The average caseload performance target was not met for Leeward Oahu and the Big Island FGCs where caseloads were above the expected range. The registered population at Leeward Oahu has shown a consistent pattern of expansion and has grown by 24% over the same period of last year, whereas the number of allocated care coordinator positions has increased by 10%. The Big Island FGC population is comparable to the same period of last year, but several care coordinator position vacancies were experienced.

**Average Caseloads by Family Guidance Center**

| | COFGC | LOFGC | MFGC | WOFGC | HOFGC | HFGC |
|---|---|---|---|---|---|---|
| 1st Quarter Average | 18 | 22 | 17 | 17 | 17 | 22 |

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

*CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight*

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is April 2005-June 2005, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the reporting quarter was under projection by $129,000. Sufficient funds were encumbered for all expected service costs.

Expenditures for Branch and Services totals were below budget. The total variance from the budget for FY 2005 was under projection by $276,000.

**Variance from Budget** (in $1,000's)

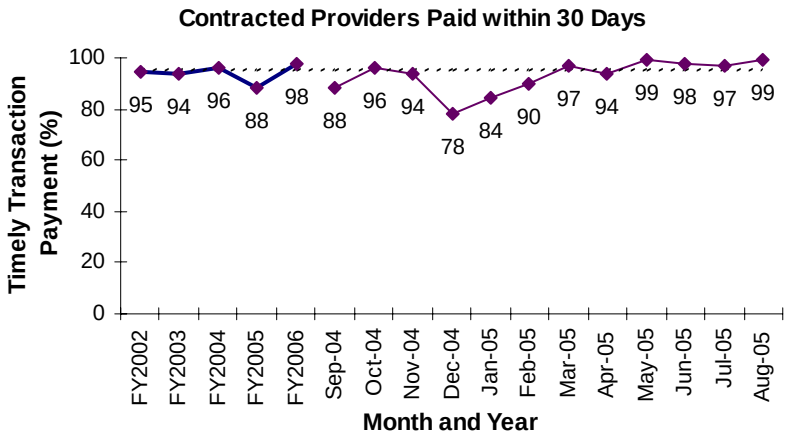
| | FY 2002 Average | FY 2003 Average | FY 2004 Average | FY2005 Average | 2004.1 | 2004.2 | 2004.3 | 2004.4 | 2005.1 | 2005.2 | 2005.3 | 2005.4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Branch Total | $164 | -$150 | $20 | -$242 | $134 | $62 | -$54 | -$60 | $20 | -$337 | -$338 | -$312 |
| Services Total | $798 | -$4,175 | -$1,849 | -$102 | $59 | -$3,963 | -$3,389 | -$101 | -$2 | -$203 | -$155 | -$49 |
| Central Office Total | -$189 | -$388 | -$314 | $68 | -$226 | -$298 | -$344 | -$388 | -$15 | -$30 | $86 | $231 |
| Grand Total | $773 | -$4,713 | -$2,142 | -$276 | -$33 | -$4,200 | -$3,787 | -$549 | $4 | -$571 | -$407 | -$129 |

*CAMHD will maintain timely payment to provider agencies*

Goal:

⇨ 95% of contracted providers are paid within 30 days.

This quarter, 98% of contractors were paid within the 30-day window over the quarter. This is a slight increase over last quarter's average of 97% of contracted providers paid within 30 days, and meets the performance goal.



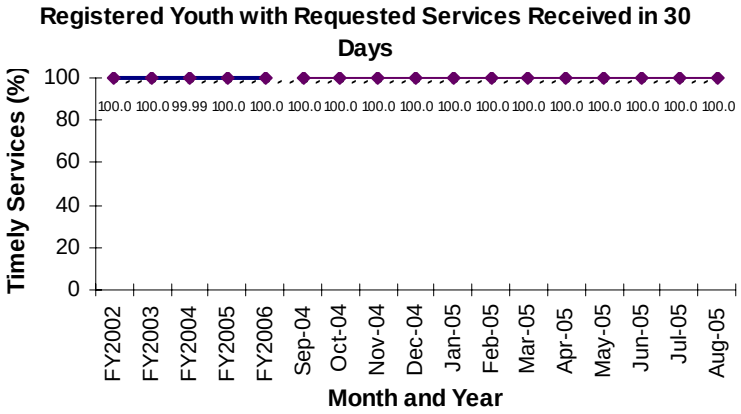

Improvement strategies implemented by the CAMHD Fiscal Section have apparently been sufficient to return to and sustain a high level of performance. As is standard for this report, the quarter's data is available for the first two months of the quarter (July and August 2005) and includes June 2005.

*CAMHD will provide timely access to a full array of community-based services*

Goal:

⇨ 98% of youth receive services within thirty days of request.*

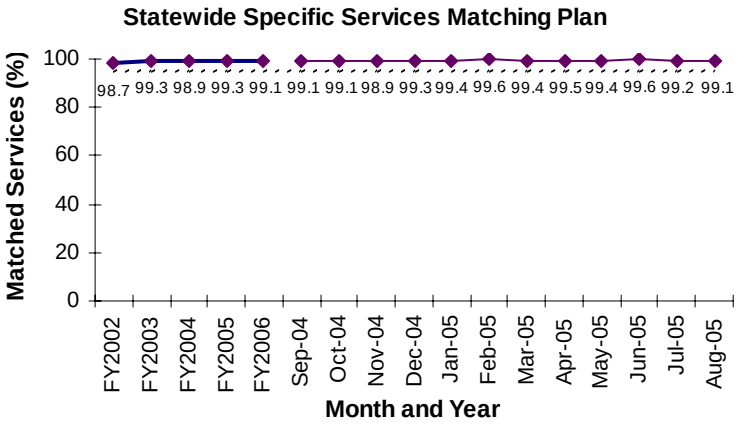
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (July and August 2005) as third month data are not available at the time of publication. June 2005 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.




Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan.*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.2% of youth received the specific services identified by their team plan. Data are for the first and second month of the reporting quarter (July and August 2005) as third month data are not available at the time of publication. June 2005 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.




In the quarter, service mismatches occurred in eighteen complexes versus twelve in the previous quarter. Hilo, Kailua, and Konawaena Complexes each had three youth receiving mismatched services. Both Castle and Kea'au Complexes had two youth receiving mismatched services. The remaining complexes experiencing mismatches had one a piece. Hilo, Kapolei, Maui, and Baldwin Complexes and Olomana had continuing mismatches from the previous quarter. Hilo has had mismatches for the last eight quarters (since June-August 2003), and Pearl City has had mismatches over the last four quarters (since June-August 2004). Analysis of the specific mismatches is regularly conducted by the regional FGCs and the Utilization Management Committee.

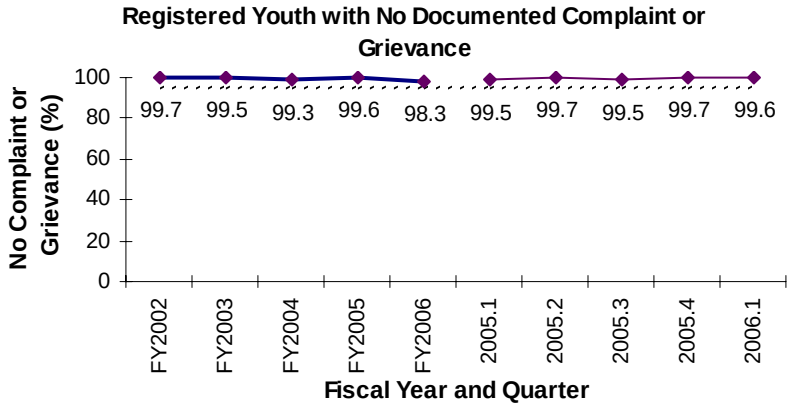
Recommendations for service expansion have been collected and are being integrated where appropriate into the RFP for the updated service array.

*CAMHD will timely and effectively respond to stakeholders' concerns*

Goal:

⇨ 95% of youth served have no documented complaint received.*

99.6% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

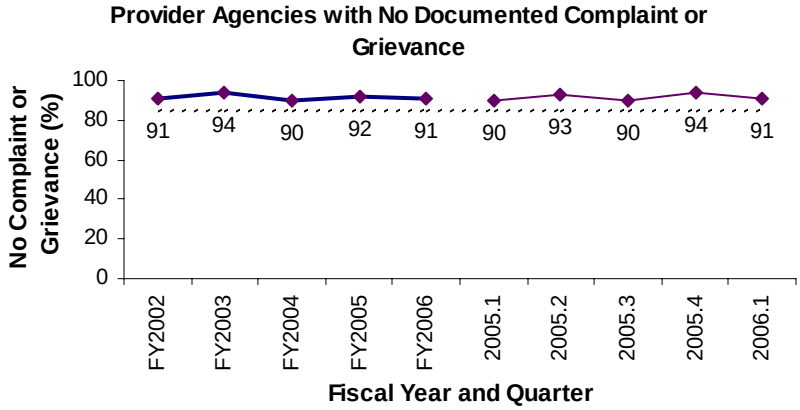



In the quarter, there were complaints received from 7 youth (or someone complaining on their behalf) representing 5 complexes statewide as compared to 10 youth with documented complaints representing 8 complexes last quarter. There was one complaint for each of the following complexes: Leilehua, Castle, Maui High, and Pahoa. Campbell received three complaints for youth in the complex. Beyond this, there were no noticeable trends in the data.

Goal:

⇨ 85% of provider agencies have no documented complaint received.

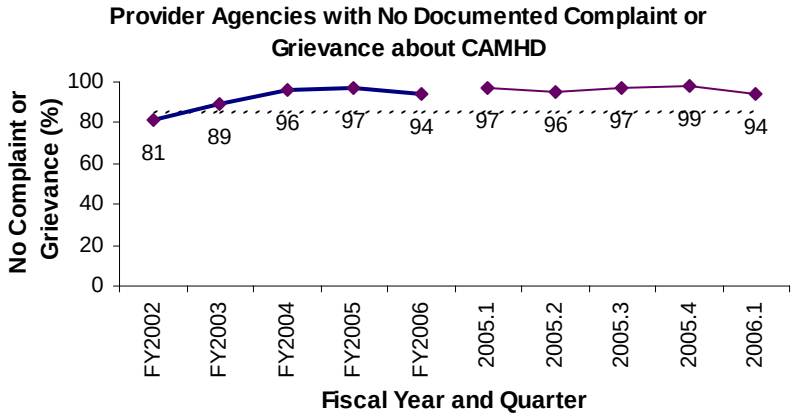
91% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance.*

In the quarter, 94% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY 2003.

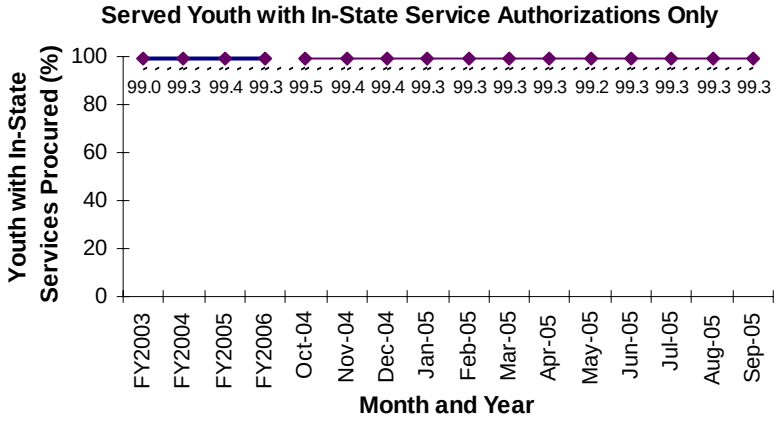



*Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting*

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii.*

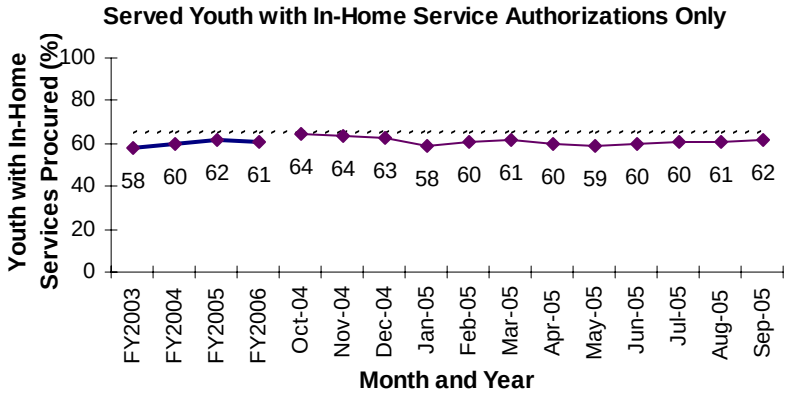
In the quarter, an average of 99.3% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in each month of the quarter. These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by other State agencies.



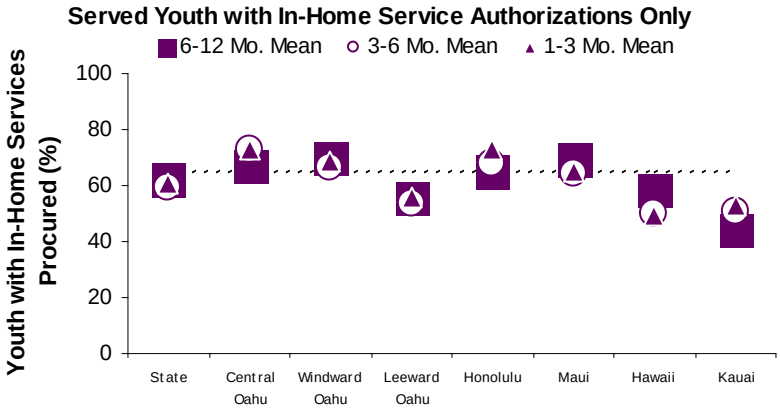

Goal:

⇨ 65% of youth are able to receive treatment while living in their home.

An average of 61% of youth were served in their home communities during the quarter, which was 4% below the performance goal. This quarter's performance is slightly above last quarter's.




There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu (72.8% served in-home), Windward Oahu (68.2% served in-home), Honolulu (72.6% served in-home), and Maui (65.3% served in-home).



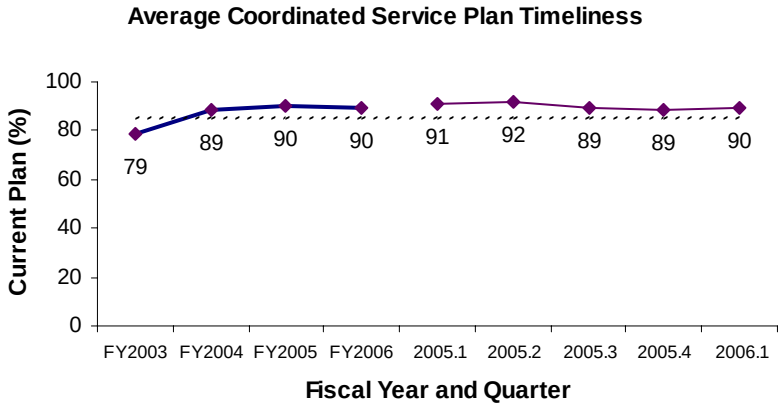

Serving youth in their homes and home communities when such services are likely to be effective continues to be a core value for CAMHD. Both the Leeward Oahu and Hawaii Family Guidance centers have historically had great out-of-home service rates, but the proportion of youth showing positive outcomes from these centers are comparable to other centers in the state. Utilization of least restrictive services within the out-of-home array is also a relevant consideration that is not reflected in this indicator, but was described in the services analysis above.

*CAMHD will consistently implement an individualized, child and family centered planning process*

Goal:

⇨ 85% of youth have a current Coordinated Service Plan (CSP).*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 90% of youth across the state having a current CSP. The performance has remained stable and the goal has been met for the past two fiscal years.

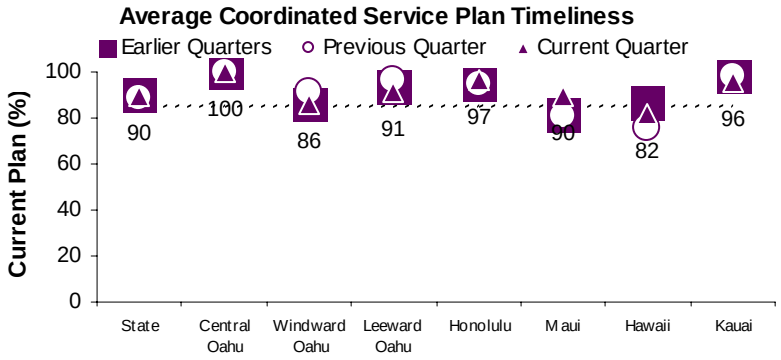



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Trend data for each FGC are displayed below. Hawaii FGC was slightly below the performance goal in the reporting period, but improved over the previous quarter. The Big Island FGC's improvement strategies of increasing supervision and filling a vacant Mental Health Supervisor position have coincided with a reversal of the trend toward declining performance on this indicator. Nevertheless, vacancies in Mental Health Care Coordinator positions and average caseloads that exceed the targeted caseload size will likely present an ongoing challenge to meeting this performance goal.

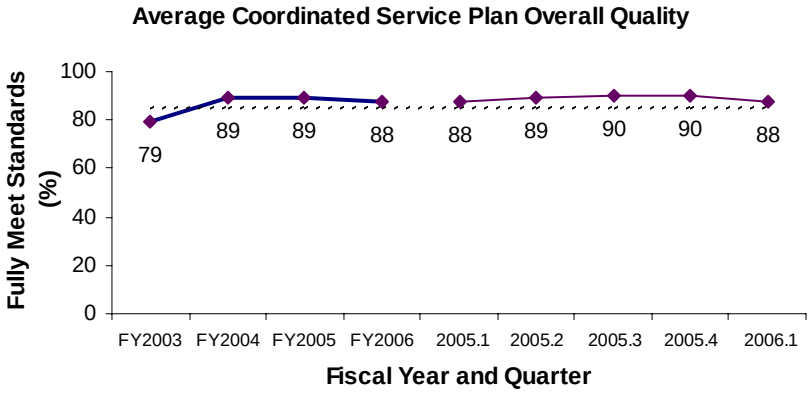
Maui FGC has improved in timeliness over the past couple quarters to exceed the performance goal this quarter. Thus, the Maui FGC's quality improvement strategies described in previous reports appear to have been successful.



Goal:

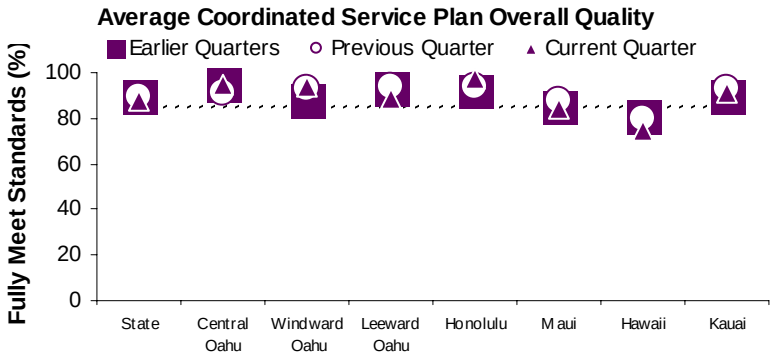
⇨ 85% of Coordinated Service Plan review indicators meet quality standards.*

The goal for this measure was met in the reporting quarter with 88% of CSPs sampled statewide meeting overall standards for quality. The goal has been met for the past two fiscal years.




CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures. During the current quarter, the specific domains with the lowest quality ratings were in contingency and crisis planning and stakeholder involvement at the CSP meetings.

As seen in the next chart, the goal was met or exceeded by all FGCs with the exception of Maui and Hawaii FGCs. This finding for Maui and the Big Island FGCs is consistent with past efforts to improve CSP timeliness and quality, which found that improvements in CSP timeliness tend to coincide with temporary decreases in quality (i.e., there is a short-term speed-accuracy tradeoff). However, ongoing improvement efforts have historically resulted in longer-term improvements in quality while maintaining sufficient timeliness, as the FGC staff establishes more efficient and effective CSP-related work habits.



*Mental Health Services will be provided by an array of quality provider agencies*

Goal:

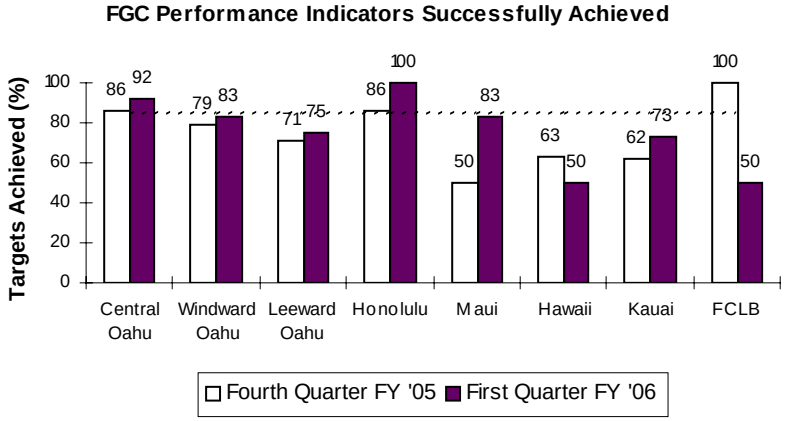
⇨ 85% of performance indicators are met for each Family Guidance Center.

Two of the eight Family Guidance Centers, Central Oahu and Honolulu, met the performance goal this quarter. Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction.

As no internal reviews were performed this quarter and family satisfaction is only measured annually, fewer indicators were included in this quarter's summary indicator than last quarter's summary. When compared to the same period of last year, when a similar indicator composition was included, all of the branches except for the Big Island FGC demonstrated stable or improving performance. Across all branches, 78.8% of all goals were met in the quarter, compared to 74.6% in the last quarter, and 75.3% over the same period last year.

Windward Oahu, Leeward Oahu, Maui, Big Island, and Kauai FGCs and the Family Court Liaison Branch (FCLB) did not meet performance goals. Windward, Leeward, and Maui showed improvement over the previous quarter and over the same period of last year. Kauai FGCs showed improvement over the previous quarter, but performance was stable compared to the same period of last year.

Due to its unique configuration, the FCLB is only evaluated for the two indicators of expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. Therefore these results tend to be highly variable and are not directly comparable to other branches.



The branches did very well on indicators of:

- maintaining within their budgets,
- timely access to services,
- documented complaints from consumers, and
- serving youth in the State.

One or two branches struggled with:

- timeliness of Coordinated Service Plans
- quality of Coordinated Service Plans
- youth showing improvements as measured by the CAFAS or ASEBA, and
- timeliness of CAFAS or ASEBA completion

Several branches struggled with:

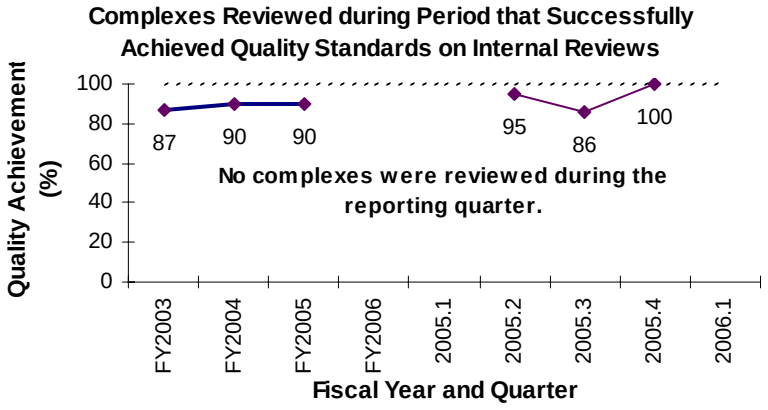
- filling their care coordinator positions,
- average caseloads,
- serving youth while they are living at home, and
- completing the CAFAS or ASEBA.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews. *

No complexes were reviewed in the reporting quarter. Internal Reviews were resumed in October. Results to date are displayed below.

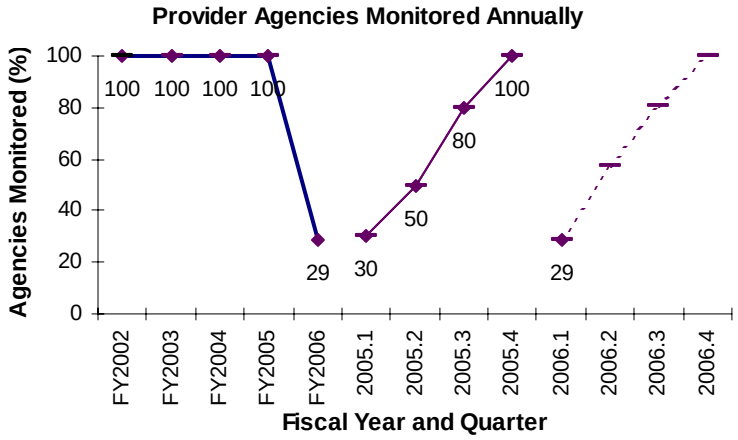


*Mental Health Services will be provided by an array of quality provider agencies*

Goal:

⇨ 100% of provider agencies are monitored annually.

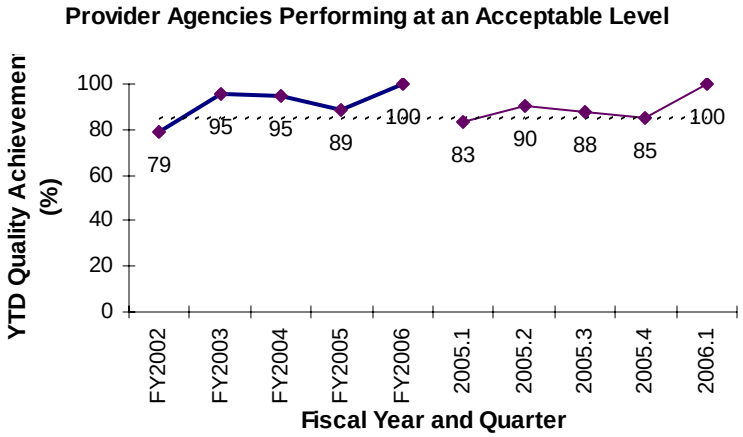
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, 29% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Six agencies, representing nine contracts and seven levels of care were monitored in the first quarter.




Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level.

At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal for this measure. Because monitoring occurs over an annual season, the quarterly indicator is not as reliable as the annual indicator. Although the improvement evident this quarter is promising, because this quarterly indicator is not a comprehensive sample of all providers, it may be due in part to the selection of a sample of agencies performing above the state average. Because fiscal year 2005 displayed a mild performance decrease of fiscal year 2004, this indicator will be monitored closely during fiscal year 2006.

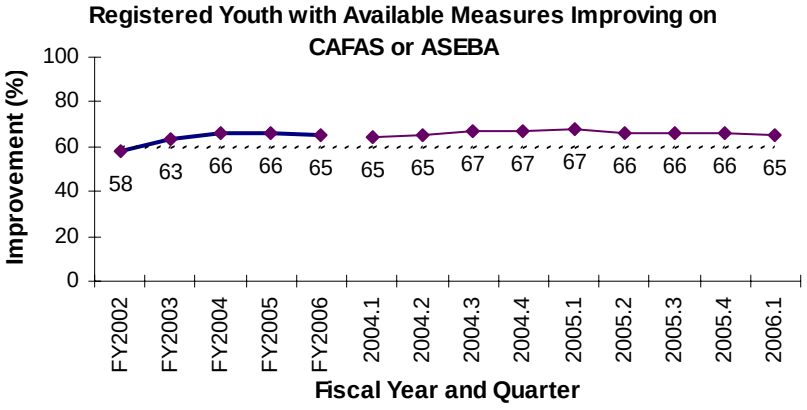



*CAMHD will demonstrate improvements in child status*

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA).*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%. In the reporting quarter, for youth with data for these measures, 65% were showing improvements since entering the CAMHD system, which exceeds the performance goal. This indicator had demonstrated improvements from fiscal year 2002 to 2004, but has settled on a new plateau of approximately two-thirds of youth showing improvement at any given point in time.



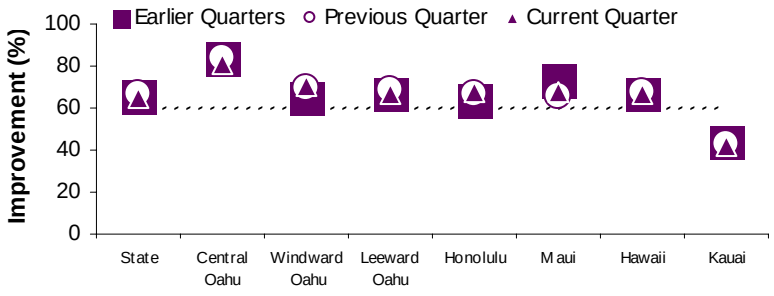

Most branches are performing near this state average, with one center, Central Oahu, performing particularly consistently well, and one center, Kauai, performing consistently below average. The pattern of performance at Central Oahu generally followed the state pattern of improvement during 2002 to 2004 and stability during the past two years.

However, during the 2002 to 2004 period of improvement, Central Oahu displayed greater gains than the other branches and moved from a slightly below average performer (54% improving) to an above average performer (81% improving).

On the other hand, Kauai never demonstrated the improvements experienced by the other branches and is performing at approximately the same level (42% improving) that it was in fiscal year 2002 (45% improving). This trend has remained stable even in the face of increases in sample quality associated with higher completion rates for the outcome measures (CAFAS or ASEBA). Thus, as expected, improvement rates are not directly correlated with sample size. In other words, the larger, more precise samples are yielding basically the same results as the smaller, less precise samples of prior periods.

Kauai differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable, but the year-to-year trends within branches are not as susceptible to bias by organizational differences. Accordingly, it is reasonable to hypothesize that some organizational change phenomena was experienced within regions throughout the state to the exclusion of Kauai.

**Registered Youth with Available Measures Improving on CAFAS or ASEBA**

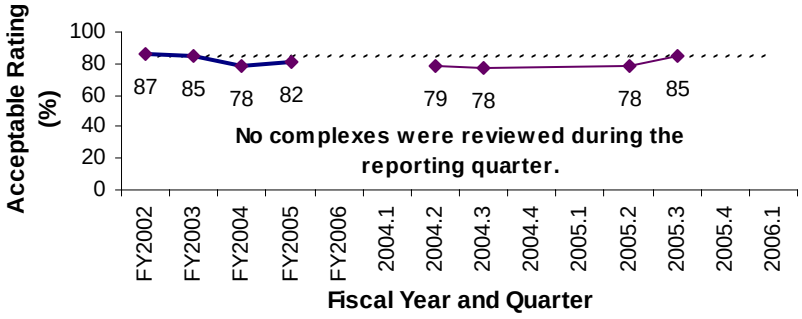



Goal:

⇨ 85% of those with case-based reviews show acceptable child status.

No Internal Reviews were conducted in the quarter. The most recent results are displayed below.

**Registered Youth with Acceptable Rating on Internal Reviews**



*Families will be engaged as partners in the planning process*

Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services.

CAMHD performs an annual consumer survey in the spring of each year and results were reported last quarter. Therefore, new data are not available for the current report. However, during the period, CAMHD was actively engaged is establishing procedures and instruments for the assessment of consumer satisfaction during fiscal year 2006.

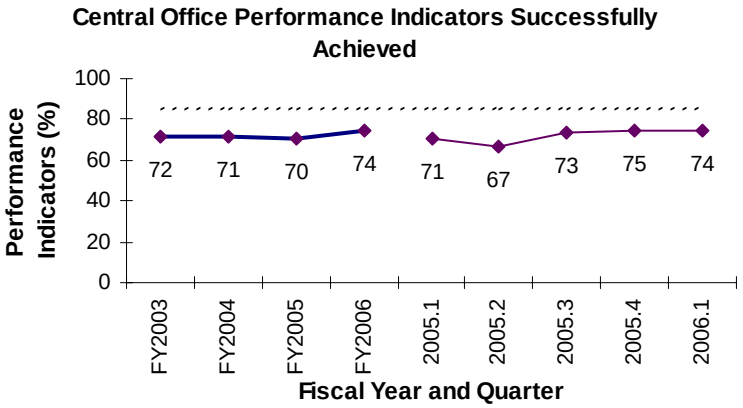
The comprehensive report of the most recent results can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs005.pdf.

*There will be state-level quality performance that ensures effective infrastructure to support the system*

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 36 measures currently tracked by EEMT. Of the 31 measures available in this quarter, 23 or 74% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator and shows a slight decrease over last quarter's performance. This continues a long-term pattern for this indicator in which mean performance fluctuates in the low 70's. In the quarter, the measures that fell below their goals continued to revolve around timeliness and issues related to the impact of staff vacancies.

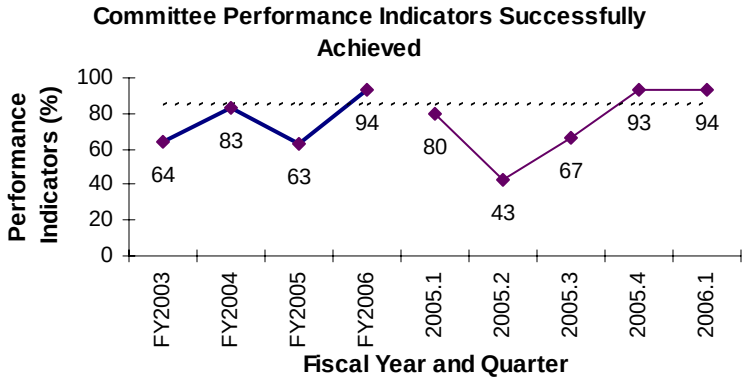



Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Complaints & Grievance, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.




A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 15 measures available in this quarter, 94% were successfully achieved through the work of the CAMHD Committees. This is a slight improvement over last quarter's performance of 93% of measures met. This is the first time since this measure began in FY 2003 that the performance target was achieved for two consecutive quarters. The only committee measure not meeting its benchmark involved the number of articles coded by the Evidence-Based Services committee during the quarter. However, this committee did successfully meet its other measures. Each committee not meeting their benchmark is required to present improvement strategies to PISC.

## Summary

The majority of performance goals were met or exceeded in the first quarter of fiscal year 2006 (July 2005-September 2005). For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 4% below targeted performance and a decrease of 3% from last quarter's performance.

The following were measures that met or exceeded goals:

- Filled Central Office positions*
- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Central Oahu Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*
- State Committee performance indicators performance indicators

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

- Youth receiving treatment while living in their homes
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- Central Office Performance indicators

The following measures were not completed this quarter due to regular annual scheduling:

- Complexes reviewed during the period that maintained acceptable scoring on Internal Reviews*
- Child Status as measured by Internal Review Results
- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

CAMHD continued to experience stable performance in most of its measures of performance. Of the 27 performance measures completed during this quarter, 18 or 67% of performance indicators met or exceeded goals. Measures that did not meet goals but had stable or improving trends constituted 19% (5 measures), and 4 or 15% did not meet goals and had declining performance. Of the original "Sustainability" measures, only one (Filled Care Coordinator positions) did not meet its performance goal, which is the same as last quarter. Challenges to filling positions remain and are actively being address through the reorganization and civil service replacement initiatives. Vacancies in the MIS and Performance Management sections continue to challenge ongoing operations. Additionally, performance areas of concern in the Family Guidance Centers are largely impacted by vacancies and the time it takes to fill positions.